UnityPoint Health
St. Luke's Hospital

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Children's Specialty Services Life Program

Intake Form

Child's Name_____Today's Date_____

Child's Date of Birth_____

Form Filled Out By_____Relationship to child_____

Child lives with (name and relationship) _____

Parent/Guardian_____

Address_____

Home Phone_____Cell Phone_____Work phone_____

Employer_____E-mail Address_____

Parent/Guardian_____

Address_____

Home Phone_____Cell Phone_____Work Phone_____

Employer_____E-mail Address_____

Child's Cell Phone_____

Is there Guardianship paperwork? _____

Others Living in the Household

Name_____Age____Relationship to and with the child

_____

_____

_____

_____

_____

_____

Strengths

Describe you child's strengths and when they feel the most successful.

As a family what are your strengths?

Family and Peer Relationships

Describe your and your partners relationship with the child.

Describer your family's method of communication (open, tense, yelling, stressed, none, loving etc.)

Current Family Stressors, contributing factors and coping strategies

Describe your child's peer relationships (do they have friends, what is the quality of friendships, and any areas of difficulties).

School Information

School the child attends_____Grade_____

Type of Classroom (general, BD, Resource, etc.)

Teacher of Contact Person_____Phone Number_____

Strengths at school

Concerns at school

Does your child have an IEP, 504 Plan or Behavior Modification Plan at school

What is your child's level of interest in learning new things? Expresses a desire for learning or, disinterest for learning. Circle which applies.

What is your child's preferred learning style? Hands on activities, Computer, Videos, Information Sheets or Discussions. Circle all that apply.

Does your child see a counselor at least weekly at school?

_____

Name_____

Does your child have a BHIS Worker who comes to the school? _____

Name_____

Describe past and current aggressive or assaultive behavior at school

_____

_____

_____

Does your child elope from the classroom or school? _____

Has your child been suspended from school?

_____

When _____

If your child is **home schooled** do they have a routine such as when they get up, do their homework etc?_____

Is your child current or behind in school? _____

Does your child attend some of the day at a school? _____

Mental Health History for the child.

Current Outpatient Counselor/Therapist

Name_____Phone_____

How effective do you feel it has been for your child

_____

_____

_____

Previous Counselor/Therapist

Name_____Phone_____

How effective do you feel it was for your child?

_____

Has your child ever been hospitalized on a psychiatric unit? If they have been

Where_____When_____

Did you find it helpful? Describe why it was helpful or why not.

_____

_____

_____

_____

Has your child ever been an alternative placement (Residential facility, PMIC, Foster Care etc.)

Where_____Date(s)_____

Was it effective? Describe why it was or why not.

_____

_____

_____

Has your child ever attempted suicide, made suicidal threats or participates in self-harm behaviors.

_____

_____

_____

If your child has made suicidal threats what was the context, they used the threat? Angry, afraid, etc. _____

What is the history of reliability regarding your child's verbal agreement to see professional assistance before engaging in behaviors that are dangerous to self or others?

_____

_____

_____

Has your child ever been sexually abused?_____
What age was the child?_____ _____

Who was the perpetrator and has your child received counseling?

_____

Has your child displayed any sexual acting out behaviors toward others? (Touched other children inappropriately, exposed themselves to others inappropriately, touched adults inappropriately, expressed inappropriate sexual thoughts or desires, or view pornography)

Has your child ever been physically abused? If yes please describe by who, how and when.

Has your child ever been a witness to Domestic Violence (physically or verbally)? If yes please describe by who, how and when.

Has your child ever experienced neglect such as being left alone at a young age, at a young age being left to care for younger siblings, no food, proper clothing or proper housing? If yes please describe by who, how and when.

Has or does your child express any obsessions, delusions, or homicidal thoughts or gestures? If yes, please explain.

Expressed any hallucinations?

Is your child compliant with taking medications? If no, please explain why.

_____

_____

Do you have any concerns about the medications your child is taking? _____

Does your child have access to Firearms or other weapons in your home, a relative's home, or a friend's home?_____

Do you have concerns about your child obtaining any weapon or affiliation with a gang?

_____

_____

_____

Explain any parent's/guardian's or child's actual or potential barriers to follow recommended or prescribed treatment.

_____

_____

_____

_____

Mental Health History of the family

Is there current or history of mental illness (anxiety, depression, ADHD, Bipolar) with child's mother or immediate family?

Who_____

Diagnosis_____

At what age was the diagnosis? _____

_____

Is there current or history of mental illness (anxiety, depression, ADHD, Bipolar) with child's father or immediate family?

Who_____

Diagnosis_____

At what age was the diagnosis? _____

Substance Use/Abuse Family and Child

Is there a history of or current drug or alcohol use/abuse with child's mother or mother's immediate family?

Who_____

What substance(s)_____

When_____

Is there a history of current drug or alcohol use/abuse with child's father or father's immediate family?

Who_____

What substance(s)_____

When_____

Does or do you know if your child uses any of the following?

Nicotiene_____Vape_____Marijuana_____Alcohol_____other drugs_____

How often_____How much_____

Is there tobacco use in the home or in the vehicle by anyone?

_____

Legal

Is there currently any HHS involvement? Name of worker_____

Phone number for worker_____

Has your child ever been charged with a crime? _____

Is your child involved with Juvenile Court?

JCO or Tracker Name_____

Phone number_____

Behavioral history and current at home or in the community

Please describe any aggressive, assaultive behaviors or destruction of property. Examples would be hitting, slapping, pushing, shoving, kicking, spitting, biting or hair pulling.

_____

_____

_____

_____

Does your child have a habit of running away from home?

_____

_____

Health History of the child

Primary Care Physician (PCP)
Name_____Phone_____

Are Immunizations up to date? _____

Has your child had any neurological assessments? _____

If yes by who? _____

Are you or anyone else worried about your child's cognition or mental status?

_____

_____

Please describe any medical conditions we need to be aware of (asthma, diabetes, seizures, bed wetting, soils self, etc.)

_____

_____

Please describe past health history such as **past** hospitalizations, surgeries, serious illnesses or injuries, head injures or loss of consciousness.

_____

_____

Do you or your child have any health beliefs or practices we should be aware of? If yes, please describe.

_____

_____

On average, how many hours does your child sleep each night?

_____

Does your child have problems with getting to sleep, staying asleep, nightmares, night terrors, or sleepwalking?

_____

_____

Do you have any concerns with your child's sexual development?

_____

_____

Is your child sexually active?

_____

Is your child questioning their sexual identity? _____

Does your child wear glasses, contacts or any type of hearing device? _____

Daily Hygiene and self-care

Does your child see a dentist on a regular basis? _____

Does your child brush their teeth at least daily? _____

How often does your child shower/bathe? _____

Occupational Therapy Screen

Has your child ever had an occupational or sensory screening? _____

Does your child appear to be seeking movement, touch, deep pressure, spinning, rocking, consistently seeking hugs, biting hands or arms, putting non-food items in mouth, head banging, pulling own hair or very heavy walking? **Circle any you feel pertain to your child.**

Is your child bothered by noise, crowds, loud voices, sirens, vacuums etc., touch from others, tags on clothes, seams in socks, avoids being messy, expresses distress with bathing, toothbrushing, etc., and or bright fluorescents lights? **Circle any you feel pertain to your child.**

Physical Therapy and Functional Screen

Has you child ever had a physical therapy screening? _____

Does your child have any difficulties with the following, walking on carpet or uneven ground, sitting, standing, getting out of bed, bathing, toileting, running, skipping, kicking balls, catching balls, riding a bike, jumping rope or hopping? Circle all that you feel pertain to your child.

Speech Screen

Has your child ever had a speech screening? _____

Does your child have any speech or language delays? _____

Can you child follow one, two and three step directions? _____

Can your child state the steps to performing a task such as how to make a peanut butter and jelly sandwich? _____

Can your child sequence event such as what they did last night, what they did first, second and third? _____

Can your child generate a simple story with a beginning, middle, and an end? _____

Pain Screen

Does your child have consistent pain from a chronic condition? _____

If yes, what is the frequency of pain? _____

What is the location of pain? _____

How long have they had the pain? _____

What makes the pain better or worse? _____

Does then pain affect their sleep, appetite, concentration, emotions, physical ability, social relationships? Please circle all that apply.

Spirituality Screen

Does your child currently practice a religion? _____

Is there anything related to their religion that would interfere with their treatment? _____

Cultural Screen

List any racial, and ethnic identity and practices

_____

_____

_____

Nutritional Screen

Circle only those numbers that apply	Yes		Yes
My child follows a special diet (prescribed or vegetarian, vegan etc.)	3	Sometimes my family does not have enough money to buy the food they need.	1
Most of the time my child eats meals alone.	2	My child takes two or more *different* medications each day (prescribed or over the counter, herbs etc.)	1
My child is pregnant or nursing a baby	6	Child or parent/guardian is worried about the child's weight.	3
My child has tooth or mouth problems that make it hard to eat.	2		
			Total the Score_____ If 0-5 You are at low nutritional risk If 6+ you are at a high nutritional risk

Has your child had a 10-pound weight gain or loss in the past 3 months? _____

Changes in appetite or smokes cigarettes? _____

Please explain any yes answers.

_____

_____

Height_____Weight_____

Allergies-Food or medication

_____

Latex Allergy _____

Children's Specialty Services Medication Information Form

Name_____ **Date**_____

Please list ALL medications your child is currently taking.	Also list any over the counter medications, herbs, vitamins, or nutritional supplements	Please list any past medication and their efficacy				
Date	Medication	Dosage	Frequency/route	Do you feel the medication is effective	Will they take while at program?	Why is your child taking this medication and has there been any side effects?

For the child who will be attending the program in their own words

List your central complaint or focus of concern you want to work on while in the program.